

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3190HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2009
NAME OF PROVIDER OR SUPPLIER HEALTHSOUTH REHABILITATION HOSPITAL OF HEI		STREET ADDRESS, CITY, STATE, ZIP CODE 10301 JEFFREYS STREET HENDERSON, NV 89052		
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S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on April 17, 2009.</p> <p>The survey was conducted using the authority of NAC 449, Hospitals, last adopted by the State Board of Health on August 04, 2004.</p> <p>The following complaints were investigated.</p> <p>Complaint #NV00016069 - Unsubstantiated Complaint #NV00021603 - Substantiated (Tag # 0221,0297, 0298) Complaint #NV00015441 - Substantiated (Tag # 0221,0297,0298)</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following regulatory deficiencies were identified.</p>	S 000		
S 221 SS=G	<p>NAC 449.340 Pharmaceutical Services</p> <p>7. Errors in administering a drug to a patient, adverse reactions by a patient to a drug and incompatibilities between a drug and patient must be immediately reported to the attending physician of the patient and, if appropriate, to the committee that oversees the quality improvement program established pursuant to NAC 449.3152. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to report an error made in medication administration that resulted in an</p>	S 221		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 221	<p>Continued From page 1</p> <p>adverse drug reaction, to the patients attending physician and to the committee that oversees the quality improvement program. (Patient #1, #2)</p> <p>Findings include:</p> <p>1. A physician history and physical dated 03/31/09, indicated Patient #1 was a 91 year old female admitted to the facility on 03/31/09 secondary to acute mental status changes after suffering a fall. The patient was taking Coumadin (an anticoagulant) for atrial fibrillation. The patient was transferred to the facility for continued medical care and a rehabilitation program and further work up for mental status changes. The patients past medical history included hypertension, dementia, atrial fibrillation, pneumonia and coronary artery disease.</p> <p>On 04/17/09 at 10:00 AM, a telephonic interview was conducted with a family member. The family member indicated the patient called and told her she had received an injection of Lovenox medication (an anticoagulant) in her naval and was concerned because it was not a medication she normally took. The family member indicated she told Patient #1 to have the nurse call her because she was aware of the patient's medications which did not include Lovenox injections. The family member indicated she was called by a registry nurse, Licensed Practical Nurse (LPN) #1 who indicated he was Patient #1's nurse. The family member indicated LPN #1 told her he gave Patient #1 an injection of Lovenox to treat DVT (deep vein thrombosis). The site bled a little but he wiped it up with alcohol. The family member indicated she became concerned because she knew Patient #1 took Coumadin not Lovenox for anticoagulation. The family member reported LPN #1 named off</p>	S 221			

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S 221	<p>Continued From page 2</p> <p>other medications that Patient #1 was not taking. LPN #1 then indicated that he was reading information from the wrong chart and had injected Patient #1 with Lovenox medication meant for her roommate.</p> <p>The family member indicated she responded to the facility and confronted LPN #1 and the charge nurse, Registered Nurse (RN) #1 about the incident. LPN #1 then denied giving Patient #1 an injection of Lovenox, but confirmed he was reading information off the wrong chart. The family member indicated RN #1 called Patient #1's physician and reported the incident. RN #1 indicated the incident could not have happened. The family member indicated prior to leaving the facility she asked Patient #1's roommate if she had received her injection of Lovenox that day and the roommate indicated she had not.</p> <p>On 04/17/09 at 9:50 AM, a telephonic interview was conducted with RN #1. RN #1 indicated she was the charge nurse on 04/11/09, and remembered the family member arrived at the facility and questioned if Patient #1 had received an injection of Lovenox. LPN #1 denied giving Patient #1 an injection of Lovenox. RN #1 indicated she conducted an investigation and called the patients physician and her supervisor and reported the incident. RN #1 indicated she checked Patient #1's stomach and could not find an injection mark in the patient's stomach that would have indicated the patient received an injection. RN #1 confirmed she did not fill out an incident report or document the incident in the nursing notes because she could not confirm a medication error occurred.</p> <p>On 04/17/09 at 2:45 PM, a telephonic interview was conducted with registry nurse LPN #1. LPN</p>	S 221			

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S 221	<p>Continued From page 3</p> <p>#1 confirmed he was Patient #1's nurse on 04/11/09. LPN #1 confirmed he administered an injection of Lovenox to Patient #1's abdomen by mistake. LPN #1 indicated the Lovenox injection was prescribed for Patient #4 not Patient #1. LPN #1 indicated he was running late and administered the medication by mistake to the wrong patient. LPN #1 acknowledged he admitted to the family member over the phone that he had given Patient #1 the Lovenox injection. LPN #1 indicated he did not admit to the charge nurse he had made a medication error when asked by the charge nurse and did not fill out a medication variance incident report or notify the physician that a medication error had occurred.</p> <p>Physician Admission medication orders dated 03/31/09 at 7:30 PM, indicated Patient #1 was ordered the following medications:</p> <ol style="list-style-type: none"> 1. HCTZ (hydrochlorothiazide) 12.5 mg (milligrams) by mouth daily. 2. Risperdal 0.25 mg by mouth twice a day. 3. Avapro 300 mg by mouth daily. 4. Toprol XL 50 mg by mouth daily. 5. Coumadin 1 mg by mouth every Monday, Wednesday, Friday and Sunday. 6. Coumadin 2 mg by mouth every Tuesday, Thursday and Saturday. 7. Levaquin 500 mg by mouth daily. 8. Senokot-S 1 by mouth twice daily. 9. Maalox ES 30 cc (cubic centimeters) every 4 hours PRN (when needed) for indigestion. 10. Dulcolax Suppository 1 rectally daily PRN constipation 11. Zofran 4 mg IV/IM (intravenous/intramuscular) every six hours PRN nausea 12. Clonidine 0.1 mg every 6 hours PRN SB (systolic blood pressure) 170 DB/P (diastolic 	S 221			

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S 221	<p>Continued From page 4</p> <p>blood pressure) 100.</p> <p>13. Ambien 5 mg by mouth at bedtime PRN for sleep.</p> <p>A review of the physician orders for Patient #1 from the date of admission, 03/31/09 to the date of discharge, 04/14/09, indicated there was no physician medication orders for Lovenox.</p> <p>A review of the medication administration records for Patient #1 from the date of admission, 03/31/09 to the date of discharge on 04/14/09, indicated there was no medication administration orders for Lovenox.</p> <p>A review of the nursing notes from the date of admission 03/31/09 to the date of discharge on 04/14/09, indicated there was no documentation of Lovenox administration or that a medication error occurred or physician was notified.</p> <p>A review of the physician progress notes from the date of admission 03/31/09 to the date of discharge on 04/14/09, indicated there was no documentation of Lovenox administration or that a medication error occurred.</p> <p>A review of Patient #1's roommate, Patient #4's medical record indicated Patient #4 had a diagnosis that included atrial fibrillation and was on deep vein thrombosis prophylactics and had a medication order dated 04/05/09, for Lovenox 30 mg SQ (subcutaneously) every day. A review of the medication administration record for Patient #4 indicated the dose of Lovenox was charted as given for each day the patient was in the hospital from 04/06/09 to 04/15/09.</p> <p>On 04/17/09 at 3:45 PM, The Chief Nursing Officer indicated the facility had no record of an</p>	S 221			

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S 221	<p>Continued From page 5</p> <p>incident report for a possible medication error for Patient #1. The Chief Nurse indicated medication errors and near misses were required to be documented on an incident report per facility policy. The incident would then be reviewed by Risk Management and Quality Assurance. The Chief Nurse confirmed per facility policy the charge nurse and house supervisor should have filled out an incident report that documented the medication incident regarding Patient #1's complaint that she received a Lovenox injection in her stomach that was not ordered for her.</p> <p>Mosby's 2008 21st Edition Nursing Drug Reference indicated Lovenox was classified as an anticoagulant and antithrombotic. The medication uses included the prevention of deep vein thrombosis and pulmonary emboli. The side effects included hemorrhage, bleeding and thrombocytopenia (decreased platelet count).</p> <p>2. The physician history and physical dated 06/28/07, indicated Patient #2 was admitted to the facility with complaints of progressive worsening nausea, vomiting and generalized weakness. The patient was found to have acute renal failure which required urgent hemodialysis. The patient had a history of diabetes, morbid obesity, hypertension, peripheral vascular disease, multiple sclerosis, and hypothyroidism.</p> <p>Patient #2 reported on the morning of 07/12/07 she was given three pills of Mysoline medication (an anticonvulsant) by her nurse. The patient suffered an adverse reaction to the medication. The patient reported being tired, lethargic and unable to keep her eyes open. The patient indicated she could not participate in physical or occupational therapy as a result of taking the</p>	S 221			

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S 221	<p>Continued From page 6</p> <p>medication. Patient #2 indicated she was offered three more pills of Mysoline medication in the afternoon but refused the medication. The patient indicated she was later told by a nurse the medication was not ordered by her physician and was administered to her by mistake.</p> <p>On 04/17/09 at 3:45 PM, the Chief Nurse confirmed there was no medication error incident report on file or in the computer system for Patient #2. The Chief Nurse reviewed Patient #2's medication administration record (MAR) for 07/12/07 and the nursing notes for 07/13/07 and acknowledged the patient received Mysoline medication in error, (the medication was not ordered for the patient) and suffered an adverse reaction to the medication. The Chief Nurse confirmed the nursing staff did not follow facility policy and procedure and notify the physician and complete an adverse drug reaction report/incident report for follow-up with Risk Management and Quality Assurance.</p> <p>A review of the physicians orders for Patient #2 from the date of admission on 06/28/07 to the date of discharge on 07/14/07 indicated there was no documented physician order for Mysoline medication administration.</p> <p>A review of Patient #2's medication administration record dated 07/12/07 documented the following:</p> <p>Primidone (Mysoline) Tab 150 mg (milligrams) PO (by mouth) 3 tab x 50 mg/ea TID (three times daily).</p> <p>The MAR documented initials by a 07/12/07 10:00 AM dose that indicated the medication was given. The 07/12/07 4:00 PM dose was refused. The 07/12/07 10:00 PM dose was refused. The</p>	S 221			

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S 221	<p>Continued From page 7</p> <p>07/13/07 10:00 AM dose was refused. The medication was discontinued on 07/13/07 with the phrase, "No Order."</p> <p>A review of physician progress notes from the date of the patient's admission on 06/28/07 to the date of discharge on 07/14/07 indicated there was no documented evidence any physician was notified Patient #2 had received Mysoline medication in error without a physicians order or the patient had suffered an adverse reaction to the medication.</p> <p>Mosby's 2008 21st Edition Nursing Drug Reference indicated Mysoline was classified as an anticonvulsant barbiturate derivative. Dosages and Routes: "Adult and child greater than 8 years old, 100-125 mg at bedtime on days 1, 2, 3; then 100-125 mg twice a day on days 4, 5, 6; then 100-125 mg three times a day on days 7, 8, 9: then maintenance 250 mg three to four times a day. Maximum dose 2 grams a day in divided doses. Side Effects: included drowsiness, irritability, psychosis, ataxia, vertigo, fatigue, emotional disturbances, mood changes, paranoia."</p> <p>A nursing note dated 07/13/07 at 8:00 AM, documented: "Client is up and in the bathroom. She states that she had a new med yesterday, Mysoline. States yesterday nurse told her she had been getting this medication since 07/09/07. Tell client that the days I had her 07/09-10-11/07 this med was not ordered for her. Check the chart, there is no order for Mysoline. D/C (discontinue) med from clients MARS. Check with pharmacy, it appears that this error was a transcription error and it came up on clients MAR 7-12 only. Checking previous MARS, client has never received this med until 7-12-07. Client</p>	S 221			

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S 221	<p>Continued From page 8</p> <p>stated she was so "knocked out" from this med that she could not participate in therapy. She states she feels much better today." (There was no documentation in the nursing notes that the physician was made aware of an error in medication administration by nursing staff or that the patient's adverse reaction to the medication was reported to the patient's physician.)</p> <p>The facility's Medication Errors Policy last revised 05/04, included "Medication errors and near misses are to be reported using existing data collection and reporting tools. The tools will be available in all patient treatment areas. Completed tools will be forwarded to Quality/Risk Management on a monthly basis. A near miss is defined as an error that was prevented from occurring."</p> <p>"Trending of errors/near misses occurring will be compiled on a monthly basis by the Director of Nursing and Pharmacist. Medication error information reported via incident reports and blood transfusion reaction reports will be included and reported in the monthly Incident Reporting Summary on the corporate intranet. Monthly data will be available to individual departments as requested. Action plan and process improvements will be implemented as trends and appropriate system modifications/changes are identified."</p> <p>The facility's Incident Report Policy last revised 01/08/09, indicated under Policy: "An incident report is to be completed for every occurrence which meets the following definition: Any happening not consistent with the routine care or operation of the facility, or the desired routine care of the patient and/or operation of the facility, which places the Company at risk for liability."</p>	S 221			

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S 221	<p>Continued From page 9</p> <p>Procedure: "The incident must be completed in ink in a timely manner, as close in real time to the event as possible, following an event which meets the above mentioned reporting definition. The Risk manager must be immediately notified if the events results in serious injury or death. All other occurrences must be reported within 24 hours of the occurrence...</p> <p>The Type of Incidents to be reported were:</p> <ol style="list-style-type: none"> 1. Falls 2. Medication Variance 3. Treatment or Procedure Variance 4. Hospital Acquired Infection/Wound 5. Equipment/Product -Related Incident 6. Miscellaneous (included any complaint voiced by a patient) 7. Other- Any unexpected incident not included in any category above whether or not there is injury..." <p>The facility's Medication Occurrences, Near Misses and Adverse Drug Events Policy VIII last revised 04/06 included: "All practitioners involved in the medication administration process are required to participate in the detection and reporting of occurrences, identification of the system based causes of occurrences, and the system modifications necessary to reduce the future occurrence of errors...</p> <p>In case of a drug administration occurrence, the following steps must be implemented:</p> <ol style="list-style-type: none"> 1. Assess the patient. 2. Notify physician. 3. Implement any needed adjustment in the patient's plan of care. 	S 221		

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S 221	Continued From page 10 4. Complete the documentation of event to include physician notification and any follow-up required. 5. Complete an incident report 6. To assist in determining the root cause of the occurrence, complete an investigation and/or Medication Occurrence Flow Chart and attach to the Incident Report. 7. Document a factual description of any adverse drug reaction, notification of physician and subsequent treatment and monitoring in the patients medical record. 8. In the case of potential or "Near Miss" event: Complete the medication "Near Miss" reporting form..." Severity: 3 Scope: 1 Complaint #NV00021603 Complaint #NV00015441	S 221		
S 297 SS=D	NAC 449.361 Nursing Service 8. The chief administrative nurse shall define the policies, procedures and standards relating to the provision of nursing services and shall ensure that the members of the nursing staff carry out those policies, procedures and standards. The policies, procedures and standards must be documented and accessible to each member of the nursing staff in written or electronic form. The chief administrative nurse must approve each element of the policies, procedures and standards before the element may be used or put into effect. This Regulation is not met as evidenced by: Based on interview, record review and document review the chief administrative nurse failed to ensure that members of the nursing staff carried	S 297		

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S 297	<p>Continued From page 11</p> <p>out policies, procedures and standards related to medication administration errors, adverse drug reaction reporting and preventable adverse drug events. (Patients #1, #2)</p> <p>Findings include:</p> <p>1.) The physician history and physical dated 03/31/09, indicated Patient #1 was a 91 year old female admitted to the facility on 03/31/09 secondary to acute mental status changes after suffering a fall. The patient was taking Coumadin (an anticoagulant) for atrial fibrillation. The patient was transferred to the facility for continued medical care and a rehabilitation program and further work up for mental status changes. The patients past medical history included hypertension, dementia, atrial fibrillation, pneumonia and coronary artery disease.</p> <p>On 04/17/09 at 10:00 AM, a telephonic interview was conducted with a family member. The family member indicated the patient called and told her she had received an injection of Lovenox medication (an anticoagulant) in her naval and was concerned because it was not a medication she normally took. The family member indicated she told Patient #1 to have the nurse call her because she was aware of the patient's medications which did not include Lovenox injections. The family member indicated she was called by a registry nurse, Licensed Practical Nurse (LPN) #1 who indicated he was Patient #1's nurse. The family member indicated LPN #1 told her he gave Patient #1 an injection of Lovenox to treat DVT (deep vein thrombosis). The site bled a little but he wiped it up with alcohol. The family member indicated she became concerned because she knew Patient #1 took Coumadin not Lovenox for anticoagulation.</p>	S 297			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3190HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2009
NAME OF PROVIDER OR SUPPLIER HEALTHSOUTH REHABILITATION HOSPITAL OF HEI			STREET ADDRESS, CITY, STATE, ZIP CODE 10301 JEFFREYS STREET HENDERSON, NV 89052		
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S 297	<p>Continued From page 12</p> <p>The family member reported LPN #1 named off other medications that Patient #1 was not taking. LPN #1 then indicated that he was reading information from the wrong chart and had injected Patient #1 with Lovenox medication meant for her roommate.</p> <p>The family member indicated she responded to the facility and confronted LPN #1 and the charge nurse, Registered Nurse (RN) #1 about the incident. LPN #1 then denied giving Patient #1 an injection of Lovenox but confirmed he was reading information off the wrong chart. The family member indicated RN #1 called Patient #1's physician and reported the incident. RN #1 indicated the incident could not have happened. The family member indicated prior to leaving the facility she asked Patient #1's roommate if she had received her injection of Lovenox that day and the roommate indicated she had not.</p> <p>On 04/17/09 at 9:50 AM, a telephonic interview was conducted with RN #1. RN #1 indicated she was the charge nurse on 04/11/09 and remembered the family member family member arrived at the facility and questioned if Patient #1 had received an injection of Lovenox. LPN #1 denied giving Patient #1 an injection of Lovenox. RN #1 indicated she conducted an investigation and called the patients physician and her supervisor and reported the incident. RN #1 indicated she checked Patient #1's stomach and could not find an injection mark in the patient's stomach that would have indicated the patient received an injection. RN #1 confirmed she did not fill out an incident report or document the incident in the nursing notes because she could not confirm a medication error occurred.</p> <p>On 04/17/09 at 2:45 PM, a telephonic interview</p>	S 297			

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S 297	<p>Continued From page 13</p> <p>was conducted with registry nurse LPN #1. LPN #1 confirmed he was Patient #1's nurse on 04/11/09. LPN #1 confirmed he administered an injection of Lovenox to Patient #1's abdomen by mistake. LPN #1 indicated the Lovenox injection was prescribed for Patient #4 not Patient #1. LPN #1 indicated he was running late and administered the medication by mistake to the wrong patient. LPN #1 acknowledged he admitted to the family member over the phone that he had given Patient #1 the Lovenox injection. LPN #1 indicated he did not admit to the charge nurse he had made a medication error when asked by the charge nurse and did not fill out a medication variance incident report or notify the physician that a medication error had occurred.</p> <p>Physician Admission medication orders dated 03/31/09 at 7:30 PM, indicated Patient #1 was ordered the following medications:</p> <ol style="list-style-type: none"> 1. HCTZ (hydrochlorothiazide) 12.5 mg (milligrams) by mouth daily. 2. Risperdal 0.25 mg by mouth twice a day. 3. Avapro 300 mg by mouth daily. 4. Toprol XL 50 mg by mouth daily. 5. Coumadin 1 mg by mouth every Monday, Wednesday, Friday and Sunday. 6. Coumadin 2 mg by mouth every Tuesday, Thursday and Saturday. 7. Levaquin 500 mg by mouth daily. 8. Senokot-S 1 by mouth twice daily. 9. Maalox ES 30 cc (cubic centimeters) every 4 hours PRN (when needed) for indigestion. 10. Dulcolax Suppository 1 rectally daily PRN constipation 11. Zofran 4 mg IV/IM (intravenous/intramuscular) every six hours PRN nausea 12. Clonidine 0.1 mg every 6 hours PRN SB 	S 297			

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S 297	<p>Continued From page 14</p> <p>(systolic blood pressure) 170 DB/P (diastolic blood pressure) 100.</p> <p>13. Ambien 5 mg by mouth at bedtime PRN for sleep.</p> <p>A review of the physician orders for Patient #1 from the date of admission, 03/31/09 to the date of discharge 04/14/09, indicated there was no physician medication orders for Lovenox.</p> <p>A review of the medication administration records for Patient #1 from the date of admission, 03/31/09 to the date of discharge on 04/14/09, indicated there was no medication administration orders for Lovenox.</p> <p>A review of the nursing notes from the date of admission 03/31/09 to the date of discharge on 04/14/09, indicated there was no documentation of Lovenox administration or that a medication error occurred or physician was notified.</p> <p>A review of the physician progress notes from the date of admission 03/31/09 to the date of discharge on 04/14/09, indicated there was no documentation of Lovenox administration or that a medication error occurred.</p> <p>A review of Patient #1's roommate, Patient #4's medical record indicated Patient #4 had a diagnosis that included atrial fibrillation and was on deep vein thrombosis prophylactics and had a medication order dated 04/05/09 for Lovenox 30 mg SQ (subcutaneously) every day. A review of the medication administration record for Patient #4 indicated the dose of Lovenox was charted as given for each day the patient was in the hospital from 04/06/09 to 04/15/09.</p> <p>On 04/17/09 at 3:45 PM, The Chief Nursing</p>	S 297			

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S 297	<p>Continued From page 15</p> <p>Officer indicated the facility had no record of an incident report for a possible medication error for Patient #1. The Chief Nurse indicated medication errors and near misses was required to be documented on an incident report per facility policy. The incident would then be reviewed by Risk Management and Quality Assurance. The Chief Nurse confirmed per facility policy the charge nurse and house supervisor should have filled out an incident report that documented the medication incident regarding Patient #1's complaint that she received a Lovenox injection in her stomach that was not ordered for her.</p> <p>Mosby's 2008 21st Edition Nursing Drug Reference indicated Lovenox was classified as an anticoagulant and antithrombotic. The medication uses included the prevention of deep vein thrombosis and pulmonary emboli. The side effects included hemorrhage, bleeding and thrombocytopenia (decreased platelet count).</p> <p>2.) a.) The physician history and physical dated 06/28/07, indicated Patient #2 was admitted to the facility with complaints of progressive worsening nausea, vomiting and generalized weakness. The patient was found to have acute renal failure which required urgent hemodialysis. The patient had a history of diabetes, morbid obesity, hypertension, peripheral vascular disease, multiple sclerosis, and hypothyroidism.</p> <p>Patient #2 indicated on the morning of 07/12/07 she was given three pills of Mysoline medication (an anticonvulsant) by her nurse. The patient suffered an adverse reaction to the medication. The patient reported being tired, lethargic and unable to keep her eyes open. The patient indicated she could not participate in physical or occupational therapy as a result of taking the</p>	S 297		

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S 297	<p>Continued From page 16</p> <p>medication. Patient #2 indicated she was offered three more pills of Mysoline medication in the afternoon but refused the medication. The patient indicated she was later told by a nurse the medication was not ordered by her physician and was administered to her by mistake.</p> <p>On 04/17/09 at 3:45 PM, the Chief Nurse confirmed there was no medication error incident report on file or in the computer system for Patient #2. The Chief Nurse reviewed Patient #2's medication administration record (MAR) for 07/12/07 and the nursing notes for 07/13/07 and acknowledged the patient received Mysoline medication in error, (the medication was not ordered for the patient) and suffered an adverse reaction to the medication. The Chief Nurse confirmed the nursing staff did not follow facility policy and procedure and notify the physician and complete an adverse drug reaction report/incident report for follow-up with Risk Management and Quality Assurance.</p> <p>A review of the physicians orders for Patient #2 from the date of admission on 06/28/07 to the date of discharge on 07/14/07, indicated there was no documented physician order for Mysoline medication administration.</p> <p>A review of Patient #2's MAR dated 07/12/07, documented the following:</p> <p>Primidone (Mysoline) Tab 150 mg (milligrams) PO (by mouth) 3 tab x 50 mg/ea TID (three times daily).</p> <p>The MAR documented initials by a 07/12/07 10:00 AM dose that indicated the medication was given. The 07/12/07 4:00 PM dose was refused. The 07/12/07 10:00 PM dose was refused. The</p>	S 297			

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S 297	<p>Continued From page 17</p> <p>07/13/07 10:00 AM dose was refused. The medication was discontinued on 07/13/07 with the phrase, " No Order " .</p> <p>A review of physician progress notes from the date of the patient's admission on 06/28/07 to the date of discharge on 07/14/07 indicated there was no documented evidence any physician was notified by the nursing staff that Patient #2 had received Mysoline medication in error without a physicians order or that the patient had suffered an adverse reaction to the medication.</p> <p>Mosby's 2008 21st Edition Nursing Drug Reference indicated Mysoline was classified as an anticonvulsant barbiturate derivative. Dosages and Routes: "Adult and child greater than 8 years old, 100-125 mg at bedtime on days 1, 2, 3; then 100-125 mg twice a day on days 4, 5, 6; then 100-125 mg three times a day on days 7, 8, 9: then maintenance 250 mg three to four times a day. Maximum dose 2 grams a day in divided doses. Side Effects: included drowsiness, irritability, psychosis, ataxia, vertigo, fatigue, emotional disturbances, mood changes, paranoia."</p> <p>A nursing note dated 07/13/07 at 8:00 AM, documented: "Client is up and in the bathroom. She states that she had a new med yesterday, Mysoline. States yesterday nurse told her she had been getting this medication since 07/09/07. Tell client that the days I had her 07/09-10-11/07 this med was not ordered for her. Check the chart, there is no order for Mysoline. D/C (discontinue) med from clients MARS. Check with pharmacy, it appears that this error was a transcription error and it came up on clients MAR 7-12 only. Checking previous MARS, client has never received this med until 7-12-07. Client</p>	S 297			

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S 297	<p>Continued From page 18</p> <p>stated she was so "knocked out" from this med that she could not participate in therapy. She states she feels much better today." (There was no documentation in the nursing notes that the physician was made aware of an error in medication administration by nursing staff or that the patient's adverse reaction to the medication was reported to the patient's physician.)</p> <p>b.) Patient #2 reported on 06/29/07 in the morning, her nurse indicated she was to receive 100 units of Lantus Insulin ordered by her physician. Patient #2 indicated she questioned the insulin dose and thought the dose was too high. Patient #2 called her daughter who was a nurse and was told not to take 100 units of Lantus Insulin because that dose could be fatal.</p> <p>Physician Orders dated 06/28/07, indicated the patient was prescribed Lantus Insulin 15 units SQ (subcutaneously) every morning.</p> <p>The medication record for 06/29/07 documented the following:</p> <p>Insulin Lantus: 100 unit's inj (injectable) 1 Lantus Sub Q AM (subcutaneously every morning) Do Not Mix with other Insulin's High-Risk med- 2 Nurses to Verify Dose Dose is 15 Units</p> <p>On 04/17/09 at 3:45 PM, the Chief Nurse reported there was no medication error incident report on file or in the computer system for Patient #2. The Chief Nurse reviewed Patient #2's medication administration record (MAR) for Lantus Insulin medication administration and acknowledged a nurse could easily misinterpret the order to read Lantus Insulin 100 units was to be given instead of 15 units. The Chief Nurse</p>	S 297			

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S 297	<p>Continued From page 19</p> <p>acknowledged an incident where a nurse misinterpreted an insulin order and attempted to give 100 units of Lantus Insulin instead of 15 units of Lantus Insulin would fall within the facility's definition of a "Near Miss" medication incident and should per facility policy be documented on an incident report.</p> <p>Mosby's 2008 21st Edition Nursing Drug Reference indicated under Action: "Lantus Insulin decreases blood glucose; by transport of glucose into cells and the conversion of glucose to glycogen. Uses: treatment of diabetes mellitus. Dosage: Adult and child greater or equal to 6 years. Ten international units subcutaneously daily, range 2-100 international units/day. Side Effects: included sweating, weakness, dizziness, chills, confusion, rapid weak pulse, memory lapses, anxiety, tremors."</p> <p>The facility's Medication Errors Policy last revised 05/04, included,"Medication errors and near misses are to be reported using existing data collection and reporting tools. The tools will be available in all patient treatment areas. Completed tools will be forwarded to Quality/Risk Management on a monthly basis. A near miss is defined as an error that was prevented from occurring."</p> <p>"Trending of errors/near misses occurring will be compiled on a monthly basis by the Director of Nursing and Pharmacist. Medication error information reported via incident reports and blood transfusion reaction reports will be included and reported in the monthly Incident Reporting Summary on the corporate intranet. Monthly data will be available to individual departments as requested. Action plan and process improvements will be implemented as trends and</p>	S 297			

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S 297	<p>Continued From page 20</p> <p>appropriate system modifications/changes are identified."</p> <p>The facility's Incident Report Policy last revised 01/08/09, indicated under Policy: "An incident report is to be completed for every occurrence which meets the following definition: Any happening not consistent with the routine care or operation of the facility, or the desired routine care of the patient and/or operation of the facility, which places the Company at risk for liability."</p> <p>Procedure: "The incident must be completed in ink in a timely manner, as close in real time to the event as possible, following an event which meets the above mentioned reporting definition. The Risk manager must be immediately notified if the events results in serious injury or death. All other occurrences must be reported within 24 hours of the occurrence."</p> <p>"The Type of Incidents to be reported were:</p> <ol style="list-style-type: none"> 1. Falls 2. Medication Variance 3. Treatment or Procedure Variance 4. Hospital Acquired Infection/Wound 5. Equipment/Product -Related Incident 6. Miscellaneous (included any complaint voiced by a patient) 7. Other- Any unexpected incident not included in any category above whether or not there is injury." <p>The facility's Medication Occurrences, Near Misses and Adverse Drug Events Policy VIII last revised 04/06, included: "All practitioners involved in the medication administration process are required to participate in the detection and reporting of occurrences, identification of the</p>	S 297			

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S 297	<p>Continued From page 21</p> <p>system based causes of occurrences, and the system modifications necessary to reduce the future occurrence of errors."</p> <p>"In case of a drug administration occurrence, the following steps must be implemented:</p> <ol style="list-style-type: none"> 1. Assess the patient. 2. Notify physician. 3. Implement any needed adjustment in the patient's plan of care. 4. Complete the documentation of event to include physician notification and any follow-up required. 5. Complete an incident report 6. To assist in determining the root cause of the occurrence, complete an investigation and/or Medication Occurrence Flow Chart and attach to the Incident Report. 7. Document a factual description of any adverse drug reaction, notification of physician and subsequent treatment and monitoring in the patients medical record. 8. In the case of potential or "Near Miss" event: Complete the medication "Near Miss" reporting form." <p>The facility's Medication Administration Policy last revised 04/06 included, "Prior to administering medications always confirm the five rights of medication administration...</p> <ol style="list-style-type: none"> 1. Right Dose 2. Right Medication 3. Right route 4. Right Time 5. Right Patient: Verify by checking patient's full name, birth date and verbally ask the patient, or verify with identification bracelet..." 	S 297		

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S 297	Continued From page 22 Severity: 2 Scope: 1 Complaint #NV00021603 Complaint #NV00015441	S 297			
S 298 SS=G	NAC 449.361 Nursing Service 9. A hospital shall ensure that its patients receive proper treatment and care provided by its nursing services in accordance with nationally recognized standards of practice and physicians' orders. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure two patients received proper treatment, medications and care by nursing services in accordance with nationally recognized standards of practice and physicians orders. (Patients #1, #2) Findings include: 1. A physician history and physical dated 03/31/09, indicated Patient #1 was a 91 year old female admitted to the facility on 03/31/09 secondary to acute mental status changes after suffering a fall. The patient was taking Coumadin (an anticoagulant) for atrial fibrillation. The patient was transferred to the facility for continued medical care and a rehabilitation program and further work up for mental status changes. The patients past medical history included hypertension, dementia, atrial fibrillation, pneumonia and coronary artery disease. On 04/17/09 at 10:00 AM, a telephonic interview was conducted with a family member. The family member indicated the patient called and told her she had received an injection of Lovenox	S 298			

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S 298	<p>Continued From page 23</p> <p>medication (an anticoagulant) in her naval and was concerned because it was not a medication she normally took. The family member indicated she told Patient #1 to have the nurse call her because she was aware of the patient's medications which did not include Lovenox injections. The family member indicated she was called by a registry nurse, Licensed Practical Nurse (LPN) #1 who indicated he was Patient #1's nurse. The family member indicated LPN #1 told her he gave Patient #1 an injection of Lovenox to treat DVT (deep vein thrombosis). The site bled a little but he wiped it up with alcohol. The family member indicated she became concerned because she knew Patient #1 took Coumadin not Lovenox for anticoagulation. The family member reported LPN #1 named off other medications that Patient #1 was not taking. LPN #1 then indicated that he was reading information from the wrong chart and had injected Patient #1 with Lovenox medication meant for her roommate.</p> <p>The family member indicated she responded to the facility and confronted LPN #1 and the charge nurse, Registered Nurse (RN) #1 about the incident. LPN #1 then denied giving Patient #1 an injection of Lovenox, but confirmed he was reading information off the wrong chart. The family member indicated RN #1 called Patient #1's physician and reported the incident. RN #1 indicated the incident could not have happened. The family member indicated prior to leaving the facility she asked Patient #1's roommate if she had received her injection of Lovenox that day and the roommate indicated she had not.</p> <p>On 04/17/09 at 9:50 AM, a telephonic interview was conducted with RN #1. RN #1 indicated she was the charge nurse on 04/11/09, and</p>	S 298			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3190HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2009
NAME OF PROVIDER OR SUPPLIER HEALTHSOUTH REHABILITATION HOSPITAL OF HEI		STREET ADDRESS, CITY, STATE, ZIP CODE 10301 JEFFREYS STREET HENDERSON, NV 89052		
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S 298	<p>Continued From page 24</p> <p>remembered the family member arrived at the facility and questioned if Patient #1 had received an injection of Lovenox. LPN #1 denied giving Patient #1 an injection of Lovenox. RN #1 indicated she conducted an investigation and called the patients physician and her supervisor and reported the incident. RN #1 indicated she checked Patient #1's stomach and could not find an injection mark in the patient's stomach that would have indicated the patient received an injection. RN #1 confirmed she did not fill out an incident report or document the incident in the nursing notes because she could not confirm a medication error occurred.</p> <p>On 04/17/09 at 2:45 PM, a telephonic interview was conducted with registry nurse LPN #1. LPN #1 confirmed he was Patient #1's nurse on 04/11/09. LPN #1 confirmed he administered an injection of Lovenox to Patient #1's abdomen by mistake. LPN #1 indicated the Lovenox injection was prescribed for Patient #4 not Patient #1. LPN #1 indicated he was running late and administered the medication by mistake to the wrong patient. LPN #1 acknowledged he admitted to the family member over the phone that he had given Patient #1 the Lovenox injection. LPN #1 indicated he did not admit to the charge nurse he had made a medication error when asked by the charge nurse and did not fill out a medication variance incident report or notify the physician that a medication error had occurred.</p> <p>Physician Admission medication orders dated 03/31/09 at 7:30 PM, indicated Patient #1 was ordered the following medications:</p> <ol style="list-style-type: none"> 1. HCTZ (hydrochlorothiazide) 12.5 mg (milligrams) by mouth daily. 2. Risperdal 0.25 mg by mouth twice a day. 	S 298		

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S 298	<p>Continued From page 25</p> <ol style="list-style-type: none"> 3. Avapro 300 mg by mouth daily. 4. Toprol XL 50 mg by mouth daily. 5. Coumadin 1 mg by mouth every Monday, Wednesday, Friday and Sunday. 6. Coumadin 2 mg by mouth every Tuesday, Thursday and Saturday. 7. Levaquin 500 mg by mouth daily. 8. Senokot-S 1 by mouth twice daily. 9. Maalox ES 30 cc (cubic centimeters) every 4 hours PRN (when needed) for indigestion. 10. Dulcolax Suppository 1 rectally daily PRN constipation 11. Zofran 4 mg IV/IM (intravenous/intramuscular) every six hours PRN nausea 12. Clonidine 0.1 mg every 6 hours PRN SB (systolic blood pressure) 170 DB/P (diastolic blood pressure) 100. 13. Ambien 5 mg by mouth at bedtime PRN for sleep. <p>A review of the physician orders for Patient #1 from the date of admission, 03/31/09 to the date of discharge, 04/14/09, indicated there was no physician medication orders for Lovenox.</p> <p>A review of the medication administration records for Patient #1 from the date of admission, 03/31/09 to the date of discharge on 04/14/09, indicated there was no medication administration orders for Lovenox.</p> <p>A review of the nursing notes from the date of admission 03/31/09 to the date of discharge on 04/14/09, indicated there was no documentation of Lovenox administration or that a medication error occurred or physician was notified.</p> <p>A review of the physician progress notes from the date of admission 03/31/09 to the date of</p>	S 298		

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S 298	<p>Continued From page 26</p> <p>discharge on 04/14/09, indicated there was no documentation of Lovenox administration or that a medication error occurred.</p> <p>A review of Patient #1's roommate, Patient #4's medical record indicated Patient #4 had a diagnosis that included atrial fibrillation and was on deep vein thrombosis prophylactics and had a medication order dated 04/05/09, for Lovenox 30 mg SQ (subcutaneously) every day. A review of the medication administration record for Patient #4 indicated the dose of Lovenox was charted as given for each day the patient was in the hospital from 04/06/09 to 04/15/09.</p> <p>On 04/17/09 at 3:45 PM, The Chief Nursing Officer indicated the facility had no record of an incident report for a possible medication error for Patient #1. The Chief Nurse indicated medication errors and near misses were required to be documented on an incident report per facility policy. The incident would then be reviewed by Risk Management and Quality Assurance. The Chief Nurse confirmed per facility policy the charge nurse and house supervisor should have filled out an incident report that documented the medication incident regarding Patient #1's complaint that she received a Lovenox injection in her stomach that was not ordered for her.</p> <p>Mosby's 2008 21st Edition Nursing Drug Reference indicated Lovenox was classified as an anticoagulant and antithrombotic. The medication uses included the prevention of deep vein thrombosis and pulmonary emboli. The side effects included hemorrhage, bleeding and thrombocytopenia (decreased platelet count).</p> <p>2. A physician history and physical dated 06/28/07, indicated Patient #2 was admitted to</p>	S 298			

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S 298	<p>Continued From page 27</p> <p>the facility with complaints of progressive worsening nausea, vomiting and generalized weakness. The patient was found to have acute renal failure which required urgent hemodialysis. The patient had a history of diabetes, morbid obesity, hypertension, peripheral vascular disease, multiple sclerosis, and hypothyroidism.</p> <p>Patient #2 reported on the morning of 07/12/07 she was given three pills of Mysoline medication (an anticonvulsant) by her nurse. The patient suffered an adverse reaction to the medication. The patient reported being tired, lethargic and unable to keep her eyes open. The patient indicated she could not participate in physical or occupational therapy as a result of taking the medication. Patient #2 indicated she was offered three more pills of Mysoline medication in the afternoon but refused the medication. The patient indicated she was later told by a nurse the medication was not ordered by her physician and was administered to her by mistake.</p> <p>On 04/17/09 at 3:45 PM , the Chief Nurse confirmed there was no medication error incident report on file or in the computer system for Patient #2. The Chief Nurse reviewed Patient #2's medication administration record (MAR) for 07/12/07 and the nursing notes for 07/13/07 and acknowledged the patient received Mysoline medication in error, (the medication was not ordered for the patient) and suffered an adverse reaction to the medication. The Chief Nurse confirmed the nursing staff did not follow facility policy and procedure and notify the physician and complete an adverse drug reaction report/incident report for follow-up with Risk Management and Quality Assurance.</p> <p>A review of the physicians orders for Patient #2</p>	S 298			

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S 298	<p>Continued From page 28</p> <p>from the date of admission on 06/28/07 to the date of discharge on 07/14/07, indicated there was no documented physician order for Mysoline medication administration.</p> <p>A review of Patient #2's medication administration record dated 07/12/07 documented the following:</p> <p>Primidone (Mysoline) Tab 150 mg (milligrams) PO (by mouth) 3 tab x 50 mg/ea TID (three times daily).</p> <p>The MAR documented initials by a 07/12/07 10:00 AM dose that indicated the medication was given. The 07/12/07 4:00 PM dose was refused. The 07/12/07 10:00 PM dose was refused. The 07/13/07 10:00 AM dose was refused. The medication was discontinued on 07/13/07 with the phrase, "No Order" .</p> <p>A review of physician progress notes from the date of the patient's admission on 06/28/07 to the date of discharge on 07/14/07, indicated there was no documented evidence any physician was notified by the nursing staff that Patient #2 had received Mysoline medication in error without a physicians order or that the patient had suffered an adverse reaction to the medication.</p> <p>Mosby's 2008 21st Edition Nursing Drug Reference indicated Mysoline was classified as an anticonvulsant barbiturate derivative. Dosages and Routes: "Adult and child greater than 8 years old, 100-125 mg at bedtime on days 1, 2, 3; then 100-125 mg twice a day on days 4, 5, 6; then 100-125 mg three times a day on days 7, 8, 9; then maintenance 250 mg three to four times a day. Maximum dose 2 grams a day in divided doses. Side Effects: included drowsiness, irritability, psychosis, ataxia, vertigo, fatigue,</p>	S 298			

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S 298	<p>Continued From page 29</p> <p>emotional disturbances, mood changes, paranoia."</p> <p>A nursing note dated 07/13/07 at 8:00 AM, documented: "Client is up and in the bathroom. She states that she had a new med yesterday, Mysoline. States yesterday nurse told her she had been getting this medication since 07/09/07. Tell client that the days I had her 07/09-10-11/07 this med was not ordered for her. Check the chart, there is no order for Mysoline. D/C (discontinue) med from clients MARS. Check with pharmacy, it appears that this error was a transcription error and it came up on clients MAR 7-12 only. Checking previous MARS, client has never received this med until 7-12-07. Client stated she was so "knocked out" from this med that she could not participate in therapy. She states she feels much better today." (There was no documentation in the nursing notes that the physician was made aware of an error in medication administration by nursing staff or that the patient 's adverse reaction to the medication was reported to the patient's physician.)</p> <p>The facility's Medication Errors Policy last revised 05/04, included,"Medication errors and near misses are to be reported using existing data collection and reporting tools. The tools will be available in all patient treatment areas. Completed tools will be forwarded to Quality/Risk Management on a monthly basis. A near miss is defined as an error that was prevented from occurring."</p> <p>"Trending of errors/near misses occurring will be compiled on a monthly basis by the Director of Nursing and Pharmacist. Medication error information reported via incident reports and blood transfusion reaction reports will be included</p>	S 298			

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S 298	<p>Continued From page 30</p> <p>and reported in the monthly Incident Reporting Summary on the corporate intranet. Monthly data will be available to individual departments as requested. Action plan and process improvements will be implemented as trends and appropriate system modifications/changes are identified."</p> <p>The facility's Incident Report Policy last revised 01/08/09, indicated under Policy: "An incident report is to be completed for every occurrence which meets the following definition: Any happening not consistent with the routine care or operation of the facility, or the desired routine care of the patient and/or operation of the facility, which places the Company at risk for liability."</p> <p>Procedure: "The incident must be completed in ink in a timely manner, as close in real time to the event as possible, following an event which meets the above mentioned reporting definition. The Risk manager must be immediately notified if the events results in serious injury or death. All other occurrences must be reported within 24 hours of the occurrence."</p> <p>"The Type of Incidents to be reported were:</p> <ol style="list-style-type: none"> 1. Falls 2. Medication Variance 3. Treatment or Procedure Variance 4. Hospital Acquired Infection/Wound 5. Equipment/Product -Related Incident 6. Miscellaneous (included any complaint voiced by a patient) 7. Other- Any unexpected incident not included in any category above whether or not there is injury." <p>The facility's Medication Occurrences, Near</p> 	S 298		

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S 298	<p>Continued From page 31</p> <p>Misses and Adverse Drug Events Policy VIII last revised 04/06, included: "All practitioners involved in the medication administration process are required to participate in the detection and reporting of occurrences, identification of the system based causes of occurrences, and the system modifications necessary to reduce the future occurrence of errors."</p> <p>"In case of a drug administration occurrence, the following steps must be implemented:</p> <ol style="list-style-type: none"> 1. Assess the patient. 2. Notify physician. 3. Implement any needed adjustment in the patient ' s plan of care. 4. Complete the documentation of event to include physician notification and any follow-up required. 5. Complete an incident report 6. To assist in determining the root cause of the occurrence, complete an investigation and/or Medication Occurrence Flow Chart and attach to the Incident Report. 7. Document a factual description of any adverse drug reaction, notification of physician and subsequent treatment and monitoring in the patients medical record. 8. In the case of potential or " Near Miss " event: Complete the medication "Near Miss" reporting form." <p>The facilities Medication Administration Policy last revised 04/06 included, "Prior to administering medications always confirm the five rights of medication administration...</p> <ol style="list-style-type: none"> 1. Right Dose 2. Right Medication 3. Right route 	S 298		

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S 298	Continued From page 32 4. Right Time 5. Right Patient: Verify by checking patient's full name, birth date and verbally ask the patient, or verify with identification bracelet..." Severity: 3 Scope: 1 Complaint #NV00015441 Complaint #NV00021603	S 298			

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